CHAPTER V

BILLING INSTRUCTIONS

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INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Department of Medical Assistance Services (DMAS) for mental health community services. Billing procedures for community mental health services are identical, except for the procedure codes used to identify the type of service rendered.

Two major areas are covered in this chapter:

- **General Information** - This is information about the timely filing of claims, claims inquiries, and billing supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of the claim forms and the submission of adjustment requests.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately, because electronic claims are entered into the claims processing system directly. For more information, contact our Fiscal Agent, First Health Services Corporation:

Phone:	1-800-924-6741
Fax number:	1-804-273-6797
First Health's website:	http://virginia.fhsc.com
Mailing Address:	EDI Coordinator - Virginia Operations First Health Services Corporation 4300 Cox Road Richmond, Virginia 23060

GENERAL INFORMATION

Timely Filing

DMAS regulations require the prompt submission of all claims. Federal regulations require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments (see the "Exhibits" section at the end of this chapter).

Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a dated letter from the local Department of Social Services (DSS) office that specifies: the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of delayed eligibility. A copy of the dated letter from the local DSS indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) Claim Form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

  For services requiring pre-authorization, all pre-authorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

- **Denied Claims** - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (12-90) Claim Form as explained under the "Instructions for the Use of the CMS-1500 (12-90) Claim Form" section explained later in this chapter.

  - Attach written documentation to verify the explanation. This documentation may be any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See the "Exhibits" section at the end of the chapter.)

- Indicate "Unusual Service" by entering "22" in Locator 24D of the CMS-1500 (12-90) Claim Form.

- Submit the claim by mailing it to:

  Department of Medical Assistance Services, Practitioner
  P. O. Box 27444
  Richmond, Virginia 23261-7444

- Submit an original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed. Proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid, as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

There is no Medicare coverage of the mental health community services. Therefore, no claims should be sent to Medicare intermediaries.

IMPORTANT: When billing on the CMS-1500 (12-90) Claim Form, Virginia Medicaid will only accept an original form printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). Additionally, only the CMS-1500 (12-90) Claim Form will be accepted; no other CMS-1500 Claim Form will be accepted.

Photocopies or laser-printed copies of the CMS-1500 (12-90) Claim Form will NOT be accepted.

The requirement to submit claims on an original CMS-1500 (12-90) Claim Form is necessary because the individual signing the invoice is attesting to the statements on the reverse side, and, therefore, these statements become part of the original billing invoice.

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) Claim Form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms, which can be copied using a standard copy machine or can be downloaded from the DMAS website (www.dmas.virginia.gov). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "Provider" in the "User" field to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS Form Order Desk at 1-804-780-0076.

For more information or if you have questions concerning the ordering of forms, call: 1-804-780-0076.

REMITTANCE VOUCHER (PAYMENT VOUCHER)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that the DMAS Provider Enrollment and Certification Unit be notified well in advance of a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages, since they serve as notifications of matters of concern, interest, and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as a clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the

Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claims adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835, the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice, please contact our Fiscal Agent, First Health Services Corporation, at 1-888-829-5373 and choose option 2 (EDI).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	In-state, toll-free long distance

Enrollee verification and claim status may be obtained by telephoning:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
1-804-965-9732	Richmond and surrounding counties
1-804-965-9733	Richmond and surrounding counties

Enrollee verification and claim status may also be obtained by utilizing the web-based Automated Response System (ARS). See Chapter I for more information.

SPECIFIC BILLING INSTRUCTIONS

No rounding up of billing units or billing with partial hours is allowed. Time spent in documentation, travel, and clinical supervision is a part of service delivery and may not be billed separately.

H2012 - Intensive In-Home Services

Unit of service is one hour. **A minimum of three hours per week must be provided to bill for the service**. (If ISP clearly documents, below three hours may be reimbursed.) If a week begins in one month and ends in another, list the hours of service for each month on separate lines (24A) of the CMS-1500 Claim Form. Case Management activities are a component of Intensive In-Home Services. Case Management (T1017) may not be billed concurrently.

H0035 Modifier HA - Therapeutic Day Treatment for Children

Units of Modifier HA service are: One unit = two hours but less than three hours per day (**must perform a minimum of two hours per day to bill for this service).** Two units = three hours but less than five hours per day. Three units = five or more hours per day.

H0035 Modifier HB for Adult Program, Non-Geriatric or H0035 Modifier HC for Adult Program, Geriatric - Day Treatment/Partial Hospitalization

Units of service are: One unit = two hours but less than four hours per day (**must perform a minimum of two consecutive hours per day to bill for the service)**. Two units = four hours but less than seven hours per day. Three units = seven or more hours per day.

H2017 - Psychosocial Rehabilitation for Adults

Units of service are: One unit = two hours but less than four hours per day (**must perform a minimum of two consecutive hours per day to bill for the service)**. Two units = four hours but less than seven hours per day. Three units = seven or more hours per day.

H0036 - Crisis Intervention

A unit of service is 15 minutes (**must provide a minimum of 15 minutes)**. Billing should be per episode.

H0039 - Intensive Community Treatment

A billing unit is one hour. As a temporary measure, time may be accumulated to reach a billable unit.

H2019 - Crisis Stabilization

A billing unit is one hour.

H0046 - Mental Health Support

One unit = one hour but less than three hours per day. Two units = three hours but less than five hours per day. Three units = five hours but less than 6.99 hours per day. Four units = seven or more hours a day. *As a temporary measure, until units can be changed,*

time may be accumulated ONLY to reach a billable unit. Service delivery time must be added consecutively to reach a billable unit of service. To prevent exhausting the annual limit, hours may be accumulated to the maximum of the unit range, rather than accumulating to the minimum of the range (one hour).

H0018 Modifier HD - Substance Abuse Residential Treatment

A unit of service is one day.

H0015 Modifier HD - Substance Abuse Day Treatment

Units of Service are: One unit = two hours but less than four hours (**must provide a minimum of two consecutive hours per day to bill for the service**). Two units = four hours but less than seven hours per day. Three units = seven or more hours per day.

H0023 - Case Management

A billing unit is one month.

H2022 Modifier HW or HK – Community-Based Residential Services for Children and Adolescents under 21 (Level A) with Modifier HW for Comprehensive Services Act (CSA) or H2022 Modifier HK for Non-CSA children and Adolescents

The unit of service is one day. Individual and group therapy, provided by licensed Medicaid providers, is billed separately and must be pre-authorized. The Place of Service code is 53. This is entered in Box 24B.

H2020 Modifier HW or HK - Therapeutic Behavioral Services (Level B) with Modifier HW for CSA or with Modifier HK for Non-CSA Children and Adolescents

The unit of service is one day. Individual and group therapy, provided by licensed Medicaid providers, is billed separately and must be pre-authorized. Individual and group therapy must be billed as outpatient therapy. The Place of Service code is 53. This is entered in Box 24B.

BILLING PROCEDURES

The CMS-1500 Claim Form is used to bill DMAS for the mental health community services provided to eligible Medicaid recipients. Different types of services cannot be combined on the same invoice for a recipient. Each recipient's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed in the envelope provided by DMAS to:

Practitioner
Department of Medical Assistance Services
P.O. Box 27444
Richmond, VA 23261-7444

Proper postage is the responsibility of the provider and will help prevent mishandling.

ELECTRONIC FILING REQUIREMENTS

The Virginia Medicaid Management Information System (VAMMIS) is HIPAA-compliant (Health Insurance Portability and Accountability Act) and, therefore, supports all electronic filing requirements and code sets mandated by legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions after December 31, 2003, are no longer accepted, and all local service codes are no longer accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

On June 20, 2003, DMAS began accepting EDI (Electronic Data Interchange) transactions according to the specifications published in the ASC X12 Implementation Guides, version 4010A1 (HIPAA-mandated). Beginning with electronic claims submitted on or after January 1, 2004, DMAS accepts only HIPAA-mandated EDI transactions. Claims in National Standard Formats will no longer be accepted. National Codes that replace Local Codes are accepted for claims with dates of service on or after June 20, 2003. National Codes became mandatory for claims with dates of service on or after January 1, 2004.

VAMMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides, version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustments to the claim(s).

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) CLAIM FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), must be used. The following instructions have numbered items corresponding to fields on the CMS-1500. The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found on page 16.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as a Billing Invoice

The purpose of the CMS-1500 Claim Form is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (See the "Exhibits" section at the end of this chapter for a sample of a CMS-1500 Claim Form).

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name

10	**REQUIRED**	**Is Patient's Condition Related To:** **Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.)** **a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (Unusual Services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**<u>I.D. Number of Referring Physician</u> - Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**CONDITIONAL**	**CLIA #**
20	NOT REQUIRED	Outside Lab?
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis, which describes the nature of the illness or injury for which the service was rendered.**

22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices on pages 14 and 15.**
23	**CONDITIONAL**	**Prior Authorization (PA) Number – Enter the PA number for the approved service.**
24A	**REQUIRED**	**Dates of Service - Enter from and through dates in a two-digit format for the month, day, and year (e.g., 08/01/00). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the two-digit CMS code which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit CMS code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services, or Supplies** **CPT/HCPCS - Enter the five-character CPT/HCPCS Code, which describes the procedure rendered or the service provided. See the attached code list for special instructions if appropriate for your service.** **Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable.** **NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.**
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.**
24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions if applicable for your service.**
24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See special instructions if applicable to your service.**

24H	**CONDITIONAL**	**EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or Family Planning Services.** **1 - Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program Services** **2 - Family Planning Service**
24I	**CONDITIONAL**	**EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**REQUIRED**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.** **2 - No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage**
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3." See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	**OPTIONAL**	**Patient's Account Number – Up to seventeen alphanumeric characters are acceptable.**
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered

33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address, ZIP Code, & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the four-digit code identifying the reason for the submission of the adjustment invoice:

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Patient payment amount changed
1026 Correcting service periods
1027 Correcting procedure/service code
1028 Correcting diagnosis code
1029 Correcting charges
1030 Correcting units/visits/studies/procedures
1031 IC reconsideration of allowance, documented
1032 Correcting, admitting, referring, prescribing, provider identification number
1033 Adjustment is for miscellaneous reasons

1053 Adjustment reason is in the miscellaneous category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the four-digit code identifying the reason for the submission of the void invoice:

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong recipient eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Recipient not my patient
1052 Void Reason is in miscellaneous category
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

SPECIAL BILLING INSTRUCTIONS - CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each Provider Manual.

When treating a restricted enrollee, the PCP's Medicaid provider number must be placed in Locator 17a and a copy of the Practitioner Referral Form (DMAS-70) must be attached to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the PCP, he/she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.
17a	When a restricted enrollee is treated on referral from the PCP, enter the PCP's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the PCP, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

MEDALLION

PCPs bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the *Physician Manual* issued by DMAS.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the CMS-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

Mental Health Community Services Provider Manual

Locator 24D **Procedures, Services, or Supplies**

CPT/HCPCS - Enter the appropriate procedure code from the following list.

MENTAL HEALTH
Non-Institutionalized Recipients

CODE	DESCRIPTION	REIMBURSEMENT RATE	
		URBAN	RURAL
H2012	**Intensive In-Home**	**70.00**	**70.00**
H0035	**Day Treatment/Children/ Adolescents**	**38.05**	**38.05**
Modifier HA			
H2022	**Community-Based Residential**	**119.20**	**119.20**
Modifier HW	**Services for Children and Adolescents under 21** (Level A)(CSA)		
H2022	**Community-Based Residential**	**119.20**	**119.20**
Modifier HK	**Services for Children and Adolescents under 21** (Level A) (non-CSA)		
H2020	**Therapeutic Behavioral Services for**	**158.93**	**158.93**
Modifier HW	**Children and Adolescents under 21** (Level B) (CSA)		
H2020	**Therapeutic Behavioral Services for**	**158.93**	**158.93**
Modifier HK	**Children and Adolescents under 21** (Level B) (non-CSA)		
H0035	**Day Treatment/Partial Hospitalization**	**36.23**	**36.23**
Modifier HB	(adult program, non-geriatric)		
H0035	**Day Treatment/Partial Hospitalization**	**36.23**	**36.23**
Modifier HC	(adult program, geriatric)		
H2017	**Psychosocial Rehabilitation**	**24.23**	**24.23**
H0036	**Crisis Intervention**	**30.79**	**18.61**
H0046	**Mental Health Support**	**91.00**	**83.00**
H2019	**Crisis Stabilization**	**89.00**	**81.00**
H0039	**Intensive Community Treatment**	**153.00**	**139.00**
H0023	**Mental Health Case Management**	**326.50**	**326.50**

SUBSTANCE ABUSE SERVICES FOR PREGNANT AND POSTPARTUM WOMEN

H0015 Modifier HD	**Day Treatment**	**60.00**	**54.00**
H0018 Modifier HD	**Residential Treatment**	**120.00**	**108.00**

Locator 24J **COB (Primary Carrier Information)**
3 - Billed and Paid (Use for patient pay.)

Locator 24K **Reserved for Local Use**

Enter the patient pay amount if applicable.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or placed in pending status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and re-bill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	**MM**	**DD**	**CCYY**	**Sequence Number (5 digits)**
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First Name:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)** _____

COMMENTS: _____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 123456789070120031 2345.) IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.virginia.gov.